

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016037

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 249

FILED MAY 14 1962

Primary Registration District No. 3043

Registrar's No. 162

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Marion</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		c. CITY OR TOWN <b>Hannibal</b>	
Length of stay in 1b <b>32 yrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Levering Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>200 N Hayden St</b>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>W.</b> Last <b>Yount</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 22, 90</b>
9. AGE (last birthday) <b>71</b>		10. IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>International Shoe Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hull, Ill.</b>	
11. BIRTHPLACE (City and state or country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Dexter Wheelock</b>		13b. MOTHER'S MAIDEN NAME <b>Cornelia Nicholson</b>	
14. NAME OF HUSBAND OR WIFE <b>Robert A. Yount</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT Address <b>Larry Boleach - Macon, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Congestive failure</b>		<b>1 week</b>	
DUE TO (c) <b>Terminal pneumonia</b>		<b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>5:00</b> a.m. <b>5:00</b> p.m. <b>5:00</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>4/24/62</b> to <b>4/30/62</b> and last saw her alive on <b>4/29/62</b>		
21. I attended the deceased from <b>4/24/62</b> to <b>4/30/62</b> and last saw her alive on <b>4/29/62</b> Death occurred at <b>5:00 A</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>J. H. Anderson M.D.</b>		22b. ADDRESS <b>1209 Broadway, Hannibal, Mo.</b>	
22c. DATE SIGNED <b>5/2/62</b>		22d. LOCATION (City, town, or county) <b>Hannibal, Mo.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 2, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grand View Cemetery</b>	
23d. FUNERAL DIRECTOR <b>Clark Funeral Home - Hannibal, Mo.</b>		23e. DATE RECD. BY LOCAL REG. <b>May 3, 1962</b>	
23f. REGISTRAR'S SIGNATURE <b>Dr. E. M. Huchey</b>		23g. REGISTRAR'S SIGNATURE <b>Lillian M. Homan</b>	

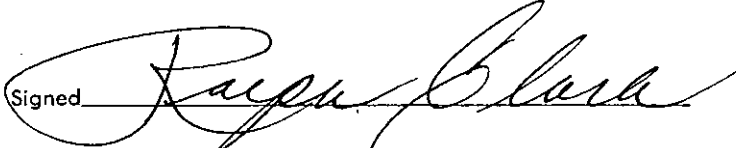
USE BLACK INK  
OR  
TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4217

P. O. Address Hannibal, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

*Permit received 5/3/62*